SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: ADMINISTRATIVE REQUIREMENTS
	Subject: Quality Assurance Process – Provider Agency Reports

Reference: 37.40.1023 and 37.40.1132

PURPOSE

The Community Services Bureau (CSB) conducts comprehensive evaluations of Community First Choice/Personal Assistance Service (CFC/PAS) provider agencies. Each provider agency is required to submit an annual Quality Assurance Report. This report documents outcomes from the provider agency's internal quality assurance review and provides assurance that the agency is meeting established program parameters. It also provides documentation to meet federal assurance standards, and identifies and responds to agency training needs.

CRITERIA

In order to participate in the CFC/PAS program, a provider agency must report on program standards outlined in the Quality Assurance Report to ensure compliance with program requirements. The provider agency **Quality Assurance Report** includes two components:

1. Internal Quality Assurance Review Summary (SLTC-250)
2. Provider Prepared Standards (SLTC-251)

INTERNAL QUALITY ASSURANCE REVIEW

The provider agency is required to conduct annual internal quality assurance reviews and submit a summary of the findings to the CSB. The internal quality assurance review documents the provider agency's compliance with the following five standards:

1. Intake Standard- Prior to the delivery of services, the member file must contain:

    a. For regular admissions; i.e. not "high risk":

        i. Person Centered Planning (PCP) Form (SLTC-200)
            1. Signed and dated by member/PR, provider agency and Plan Facilitator

ii. CFC/PAS Service Plan (SLTC-175)
    1. Signed and dated by member/PR, provider agency and Plan Facilitator

iii. Member/PR Agreement (SLTC-159/166)
    1. Signed and dated by member/PR and provider agency

iv. Health Care Professional Authorization (SLTC-160)
    1. Signed and dated by health care professional

v. Mountain Pacific Quality Health (MPQH) Overview and Service Profile (SLTC-154/155).

b. For "high risk admissions":

i. High risk temporary authorization (SLTC-175) and high risk referral to MPQH (SLTC-154)
    1. Signed and dated by member/PR and provider agency

ii. Health Care Professional Authorization
    1. Signed and dated by health care professional

2. Reauthorization Standard- Member file contains:

a. Recertification Form (SLTC-210)

i. Signed and dated by member/PR and provider agency

ii. Current Recertification form was completed by the end of the sixth month from the date the previous Recertification form was completed (i.e. if the previous recertification was dated January 10, the current recertification form must be dated no later than July 31)

b. Service Plan and Service Delivery Records reviewed

i. Recertification Form contains correct information on service utilization for the two months prior to the recertification visit

3. Annual Standard- Within one year of intake and every year thereafter, the member file must contain:

a. New PCP Form

    i. Signed and dated by the member/PR, provider agency and Plan Facilitator

b. New CFC/PAS Service Plan

    i. Signed and dated by the member/PR, provider agency and Plan Facilitator

c. New Health Care Professional Authorization

    i. Signed and dated by the health care professional

4. Person Centered Planning Standard- When a member's Plan Facilitator is the provider agency the PCP Form must contain:

    a. Member/PR initials on the PCP form at intake indicating member received the CFC/PAS handbook and reviewed contents with the Plan Facilitator;

    b. PCP Form contains information in each of the seven boxes that documents a person-centered discussion with the member related to their need and use of CFC/PAS services; and

    c. Member or Personal Representative, Plan Facilitator and Provider Agency Representative signatures and dates.

5. Health and Welfare Standard- Member's Service Plan must meet the following criteria to ensure member health and safety:

    a. Health, safety, and service needs identified on the MPQH Service Overview and Profile are addressed on the Service Plan

        i. Service Plan documents ADL and IADL tasks and frequency according to policy (refer to CFC/PAS 421)

        ii. Flexibility parameters are implemented according to policy (Refer to CFC/PAS 717)

    b. Amendment process completed when a change in condition warrants a change to the CFC/PAS Service Plan (Refer to CFC/PAS 417 and 719)

        i. Temporary authorization and amendment section completed and faxed to MPQH

ii. New Service Plan completed within 10 working days upon receipt of the amended Service Profile from MPQH

PROVIDER PREPARED STANDARDS

The provider agency is required to provide written response to the following standards:

1. Serious Occurrence- Provider reports and follows up on all serious occurrences according to policy

    a. Provider agency submits a written summary of the process provider staff use to report and responds to serious occurrences

    b. Provider agency runs the QAMS "SOR Provider Agency Detail Timeline Report" for the last six months (July-December) and reports number of incidents that were not submitted to the RPO within 10 working days.

    c. Provider agency runs a QAMS SOR Summary Report for the prior six months (July-December) and reports on the following criteria:

        i. Top three SOR incident cause and incident subtype

    d. Provider agency submits a written summary of the provider agency's plan to use the information from the SOR Timeline and Summary Report to improve member services.

2. Plan Facilitator Standard- Provider agency employs or contracts with a PCP Plan Facilitator who meets the criteria outlined in policy (refer to CFC/PAS 701)

    a. Provider agency documents the name(s) of everyone who performed the duties of the Plan Facilitator in a six month timeframe (July-December) and documents the date the Plan Facilitator(s) was determined to meet the required criteria

3. Agency Oversight Standard – Provider agency employs or contracts with Self-Direct program oversight staff who meet the criteria outlined in policy (refer to CFC/PAS 701)

    a. Provider agency submits a written summary of the process for ensuring that program oversight staff meet the required criteria prior

to performing mandatory functions of program oversight staff

b. Provider agency documents the name(s) of everyone who performed the duties of program oversight staff in a six month timeframe (July-December) and documents the date the staff was determined to meet the required criteria

4. Member Survey Standard- Provider agency conducts an annual member survey and summarize results

   a. Provider agency submits a copy of the member survey to the RPO

   b. Provider agency submits a written summary of the survey which includes at a minimum the following information:

      i. Date the survey was distributed;

      ii. Number of members who received the survey;

      iii. Number of members who responded to the survey;

      iv. Summary of survey response; and

      v. Follow-up action as a result of survey outcome.

5. Provider Enrollment Standard- Provider agencies must meet the provider enrollment criteria outlined in ARM 37.40.4017 and 37.40.1122. The provider agency must submit current documentation to verify the following:

   a. General liability insurance with a minimum coverage of $1,000,000 per occurrence and $2,000,000 aggregate;

   b. Motor vehicle liability insurance with split limits of $500,000 per person for personal injury, $1,000,000 per accident occurrence for personal injury, and $100,000 per accident occurrence for property damage; or, combined single limits of $1,000,000 per occurrence to cover such claims as may be caused by any act, omission, or negligence of the provider or its agents, officers, representatives, or subcontractors;

   c. Unemployment insurance coverage; and

   d. Worker's compensation coverage.

6. Agency Organizational Structure Standard-The provider agency submits a written summary of the provider agency's organizational structure;

including the key staff and the role(s) they play in relation to the CFC/PAS program administration. The summary should include:

a. Staff who have access to QAMS and role in QAMS;

b. Staff who review and sign off on Service Delivery Records (SDR);

c. Staff who bill Medicaid claims;

d. Staff who participate in intake, 180-day and annual visits;

e. Staff who provide CFC/PAS training; and

f. Staff who complete the Quality Assurance Report, including:

i. Staff who conduct the internal chart review

ii. Staff who complete the Provider Prepared Standards

7. Self-Direction Education Standard- Provider agency must provide member/PR with appropriate information and support to understand their role and responsibility in the self-directed program.

a. Provider agency submits the agency intake packet (excluding Department generated forms)

b. Provider agency submits a written summary of the agency process for the following:

i. Reviewing the self-directed program requirements with member/PR;

ii. Obtaining member/PR signatures on the member/PR agreement;

iii. and reviewing member/PR participation in the self-directed program on an on-going basis.

8. Agency Action Plan- The provider agency is required to submit a corrective action plan that identifies and addresses all unmet standards from the agency's Internal Quality Assurance Report summary as well as all unmet Provider Prepared Standards. The corrective action plan must include a SMART plan for each unmet standard. The SMART plan includes:

- **S**pecific to the unmet standard

- **M**easurable and includes the name of the agency staff person who will be responsible for measuring the outcome
- **A**ction specific (i.e. identify specifically how the outcome will be tracked)
- **R**elevant to the unmet standard and include a
- **T**imeframe for implementing and evaluating the action item(s)

The agency's corrective plan for each unmet standard must include SMART plans for addressing the unmet needs on an individual and system-wide basis.

For example, if a member has missed a 180-day recertification visit, the agency action plan may include two SMART goals:

1. Complete the 180-day visit with the member

    - Specific- Conduct an on-site visit
    - Measureable- Agency oversight staff, Jane Doe, will complete an on-site visit, complete the recertification form during the visit, and submit the form to office manager for tracking
    - Action Specific- Office manager, Suzie Q, will review the recertification form and document it's completion in the tracking system
    - Relevant- Recertification visit criteria will be met once the action has taken place
    - Timeframe- the visit will occur by the 5th of October

2. Determine repayment for claims billed when there was no reauthorization visit

    - Specific-Conduct a review of claims to determine the amount of money billed when the reauthorization had expired
    - Measureable-Claims specialist, John Smith, will conduct a query of member claims by date of service
    - Action Specific-John Smith will contact Regional Program Officer to determine options for repayment
    - Relevant-Repayment will ensure that claims were billed according to policy
    - Timeframe- John Smtih will conduct query by October 10th and contact RPO by October 20th

PROCESS

1. All CFC/PAS provider agencies are required to submit a **Quality Assurance Report** on an annual basis. The report is due on **April 1st each year**. When a provider agency has regional offices the report must be completed for each regional office. The report must include an internal review of member charts for the period of time July 1-December 31.

   Note: Exceptions to the requirement for a statewide provider agency with regional offices to submit the Quality Assurance Report by region must be approved through the CSB program manager prior to implementation.

2. The report must be submitted to the CSB Regional Program Officer (RPO) by the first of April. A complete list of the RPOs are listed on the Department's website at: http://dphhs.mt.gov/SLTC/csb/RPO

3. The provider agency is required to conduct an internal review of member charts that includes, at a minimum, the following sample size:

   a. Fifty percent (50%) member intakes over the last six months of the calendar year (i.e. July-December); and

   b. A caseload sample for members served in the month of December, excluding all intakes from July-December. Refer to the following chart for sample size criteria:

   - Over 250 members: 25 member sample
   - 51-250 members: 10% member sample
   - 0-50 members: 5 member sample

   1. The provider agency must use a random sample to determine the member sample. The sample must be pulled from the total member population served during the month of December.

      For example, if a provider agency had a caseload of 160 members, excluding intakes, in December the provider agency would have to review a member sample of 10% of 160; which is 16 members.

   2. When a statewide provider agency has regional offices the provider agency has two options to determine the random sample:

a. Option 1- each regional office conducts a 10% sample (no greater than 25 cases)

b. Option 2- the agency determines the sample based on the total statewide caseload and conducts a stratified random sample that ensures representative charts from every regional office are included in the sample.

For example, if a statewide provider had a total of 300 members, the agency would be required to have a member sample of 25 members. If the agency had five regional offices, each region would have to complete a review of at least 5 member files (5 cases x 5 offices = 25). If the same agency had 3 regional offices, each regional office would have to complete a review of at least 9 charts (9 cases x 3 offices = 27).

4. The provider agency is required to conduct an internal review of member charts for a six month period (July-December) to document compliance in the five internal quality assurance review standards, outlined above.

5. The provider agency may use an internal tracking mechanism to document internal quality assurance chart review.

6. The provider agency must provide a report to the RPO, upon request, of the member files that were reviewed.

7. The provider agency must summarize the internal tracking of the member charts on the Internal Quality Assurance Review; which is a form provided by the Department (Refer to CFC/PAS 924).

8. The provider agency must achieve 100% compliance in the internal member chart review. If 100% compliance is not achieved, a summary of the agency's corrective action plan must be outlined in the Provider Prepared Standards portion on the provider agency's Quality Assurance Report.

9. The provider agency must complete the Provider Prepared Standards; which is a form provided by the Department (Refer to CFC/PAS 925).

10. The provider agency has three months to complete all of the components of the Quality Assurance Report. (See below).

TIMELINE

January	Provider agency identifies random sample for an internal chart review.
January-March	Provider agency determines intake sample and caseload sample and completes an internal review of member charts for the sample. Agency summarizes results on the Internal Quality Assurance Review form. Provider agency completes the Provider Prepared Standards.
April 1	Provider agency submits the Quality Assurance Report to RPO.
July 1	RPO responds to provider agency's Quality Assurance Report in QAMS and provides follow-up, as needed.